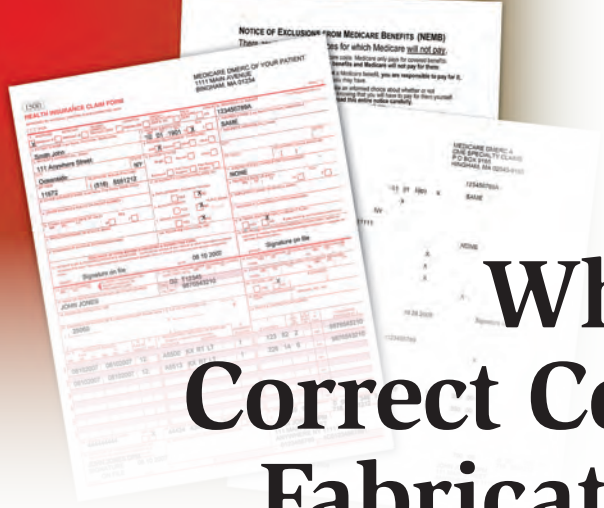

What's the Correct Code for Custom Fabricated Orthotics?

Here's what you need to know to avoid claim denials.

BY PAUL KESSELMAN, DPM

Recently, a colleague received a rejection for an L3000 custom orthotic from a large nationwide third-party payer. The issue over which code is the correct code for custom fabricated orthotics is the subject of this month's DME for DPMs. Upon speaking with this practitioner, it appears that his claim for custom orthotics was denied, despite the following:

- Medical necessity was documented over several dates of service prior to casting of an adult patient within the plan's list of covered diagnoses;
- The patient was casted using plaster splints;
- A laboratory order form was completed with no heel cup depth listed;
- Custom molded orthotics were fabricated for which there was a supporting invoice from the laboratory;
- A claim was submitted with HCPCS codes L3000 left and right (the plan did not require KX modifier);
- A dispensing note was provided indicating the date it was dispensed; and
- The patient signed a written proof of delivery on the same date as the chart's dispensing note and claim form.

The third-party payer (name rescinded) denied the claim because they stated that the chart had to specifically state that a UCB-type Berkeley shell was manufactured.

Having reviewed all the documentation and having reviewed hundreds of other charts subject to either pre-payment denial and/or post-payment recoupment, it became rather clear where the problems for this practitioner may be:

1) No heel cup depth was provided to the laboratory.

2) The laboratory order form provided many orthotic choices, all with proprietary names for this specific laboratory. However, one stood out as a generic description: a UCBL device for children was one of the choices listed on the laboratory's order form but was not chosen.

3) The third-party payer's policy for L3000 only mentioned a UCBL Berkeley Shell.

These issues are quite common scenarios but fortunately the prescriber can easily avoid such denials, with some corrective measures:

1) Be sure to document a minimum of 10mm heel cup depth on the order form. Most orthotic prescription forms either don't provide a default listing of heel cup depth or only provide choices of minimal, moderate, deep, and extra-deep. If the latter, these terms may not be defined on the laboratory order form. Without knowing how deep the heel cup is, the insurance company may assume there is minimal to no control of the hindfoot and rather than downcode the claim to another custom fabricated orthotic code (L3010 or L3020), the carrier may simply deny the claim. In this specific scenario, the third party-payer did not have a minimum heel cup depth requirement listed in their policy. In other instances, if the carrier does stipulate a heel cup depth requirement for L3000, a 10mm heel cup depth should be met or exceeded.

Fortunately, the prescriber can easily avoid such denials with some corrective measures.

2) Speak with your orthotic laboratory and request that any references to UCBL or UCB-type be removed from any one specific orthotic device. Rather, the order form should stipulate that all orthotics with a heel cup of or exceeding 10mm meet the requirements of a UCB-type custom fabricated orthotic. Doing this can avoid having the auditor simply reject your claim form because the one orthotic on the claim form which stipulates UCBL or UCB Type was not ordered. Some orthotic laboratories in response to audits in several states have already developed such standardized orthotic forms. Others, while resistant to removing UCB-type altogether, may be willing to make reasonable accommodations for individual practices. In such cases, laboratories will specify the heel cup depths

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for all their devices and quantify minimal, moderate, deep, and extra-deep to your standards for a custom order form for your practice. They will also stipulate that all their devices are UCB type if the heel cup exceeds 10mm.

3) In any case, a UCBL device should not ever be listed.

4) Inform the third-party payer that UCBL is no longer in business and that any reference to a proprietary device is not listed within HCPCS under L3000, L3010, or L3020.

APMA, AOPA, PFA and several other associations representing orthotic prescribers and providers have worked both collaboratively and diligently over the past decade. This is an attempt to remove the UCB reference from the HCPCS definition. Representatives from the three aforementioned associations have provided in-depth testimony at two recent CMS committee hearings, supporting a redefinition of the three main HCPCS codes which represent custom fabricated foot orthotics. It is important to remember that, in most cases, foot orthotics are not covered by Medicare. Nevertheless, CMS owns HCPCS codes and thus they are the agency which owns the HCPCS set and their coding narratives.

In the interim, most of the third-party payers have incorporated a 10mm heel cup minimum requirement for reimbursement for L3000 as has been endorsed by APMA, AOPA, and PFA. Each of these associations has a collaboratively developed white paper available on their websites. This white paper documents the recommended narratives for the three custom fabricated foot orthotic HCPCS codes.

To summarize, prior to submission of any orthotic claim, be sure that there are no conflicts within any of the supporting documents. This includes chart notes, laboratory order forms, and written proof of delivery. Review the laboratory order form to ensure that if submitting a claim for L3000, either the carrier's heel cup requirement for L3000 is met or exceeded. If no heel cup depth is provided in the third-party payer's policy, be sure the heel cup meets or exceeds 10mm in depth.

Members of APMA, AOPA, and PFA are urged to view the collaborative white paper available on the associations' websites. **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.